STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 01 B. WING	04/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEALTH CARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN46231

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/19/11 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Washington Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in all resident rooms. The facility has a	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a desk review or post survey visit on or after 5/16/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	capacity of 94 and had a census of 84 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/27/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 3 doors serving hazardous areas such as a kitchen was held open only by a device arranged to automatically close the door, or close it upon activation of the fire alarm system. This deficient practice affects kitchen staff and residents and visitors in the main	K0021	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The kitchen door to the dining room was updated with automatic closure with activation of fire alarm system.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective	05/16/2011

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	dining room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m., the kitchen door to the main dining room was held open by a door stop which would not allow the door to close automatically, or upon activation of the fire alarm system. Based on interview at the time of observation, the Maintenance Director stated the kitchen door to the main dining room is not held open by a device arranged to automatically close the door upon activation of the fire alarm system and acknowledged a door stop was used to hold the kitchen door to the main dining room open. 3.1-19(b)		action will be taken?Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?Door stop was removed from the kitchen door. In accordance with fire alarm testing, maintenance director or designee will ensure proper functioning of doors recquiring automatice closure with activation of fire alarm system. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A CQI tool for Life Safety Review will be utilized weekly x 4, monthly x 2, and quarterly thereafter. The CQI Committee will review the data. If threshold is not achieved, an action plan will be developed.	

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K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 openings through the ceiling into the attic above the Boiler room and 1 of 1 openings through the ceiling into the attic above the Family Conference room storage were maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any resident, staff or visitor in the vicinity of the Boiler room and the Family Conference room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 04/19/11, there is an eight inch diameter hole in the ceiling in the Boiler room which is not firestopped. Based on interview at the time of observation, the Maintenance Director stated furnace ductwork used to pass through the ceiling in the boiler room but has been taken out,	K0025	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? The 8 inch opening in ceiling in boiler room, and the 6 inch opening in the Family Conference Room storage room were repaired and firestopped on 4/22/11 by maintenance staff. A building review was completed on 5/6/11 with no further concerns in smoke barriers identified. How will you identify other Residents having the potential to be affected by the same deficient practice? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? When renovation or repairs occur in the future, facility will review areas to ensure these areas are maintained to provide at least a one half hour fire resistance ratinig. Another	05/16/2011

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	and acknowledged the eight inch opening is not firestopped. Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 04/19/11, the Family Conference room storage room has one opening in the ceiling measuring six inches in diameter. Based on interview at the time of observation, the Maintenance Director stated a previous water leak into the building caused the opening in the ceiling and acknowledged the six inch diameter opening in the Family Conference room storage room is not firestopped. 3.1-19(b)		building review will be conducted by 5/16/11 to ensure no further concern in smoke barriers.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A CQI tool for Life Safety Review will be utilized weekly x 4, monthly x 2, and quarterly thereafter. The CQI Committee will review the data. If threshold is not achieved, an action plan will be developed.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 doors serving hazardous areas such as a soiled utility room used for trash collection is	K0029	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?A new self-closing device was installed on the soiled utility room door on	05/16/2011

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	equipped with self closing devices on the door. This deficient practice could affect any resident, staff or visitor in the vicinity of Memory Care soiled utility room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 04/19/11, the Memory Care soiled utility room was being used to store one thirty two gallon barrel filled with trash and the entry door to the soiled utility room is not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the Memory Care soiled utility room was being used to store trash and the entry door is not equipped with a self closing device. 3.1-19(b)		the Memory Care unit on 4/22/11.How will you identify other Residents having the potential to be affected by the same deficient practice? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practiceWhat measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?A review of all soiled utility room doors was performed on 5/6/11. Another review will be completed on 5/16/11 to ensure proper functioning of soiled utility room doors to have self-closing device. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A CQI tool for Life Safety Review will be utilized weekly x 4, monthly x 2, and quarterly thereafter. The CQI Committee will review the data. If threshold is not achieved, an action plan will be developed.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors	K0038	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?Exit access code was posted at employee exit.How will you identify other Residents having the potential to	05/16/2011

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	within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects any resident, staff or visitor needing to exit the facility through the employee exit. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 04/19/11, all exit doors are magnetically locked and could be opened by entering a four digit code. The exit access code was posted at all exits except for the employee exit which is marked with an exit sign for all occupants in the facility and the Memory Care exit. Based on interview during the exit conference at 1:10 p.m. on 04/19/11, the Administrator stated residents near the Memory Care exit have a clinical diagnosis requiring specialized security measures and acknowledged the exit access code is not		be affected by the same deficient practice? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practiceWhat measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? When renovation or repairs occur in the future, facility will review areas to ensure that exit access is arranged so that exits are readily accessible at all times. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A CQI tool for Life Safety Review will be utilized weekly x 4, monthly x 2, and quarterly thereafter. The CQI Committee will review the data. If threshold is not achieved, an action plan will be developed.	

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	posted at the Memory Care exit but the employee exit is an exit for all occupants in the facility and acknowledged the exit access code was not posted at the employee exit. 3.1-19(b)			
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation, record review and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 3 of 3 battery operated emergency lights. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½-hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents.	K0046	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?Battery operated emergency lights test log implemented with testing to be completed by 5/16/11.How will you identify other Residents having the potential to be affected by the same deficient practice? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practiceWhat measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?Battery Operated Lights Test Log implemented and will be completed by maintenance staff monthly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put	05/16/2011

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 04/19/11, there are three battery operated emergency lights located in the facility. Based on record review with the Maintenance Director from 9:30 a.m. to 10:45 a.m. on 04/19/11, "Battery Operated Emergency Lights Test Log for (Year): 2010" documents thirty day interval functional testing for each of the three battery operated emergency lights for the period April 2010 to December 2010. A log of thirty day interval functional testing or annual testing for each battery operated emergency light for not less than 1 ½-hour duration for 2011 was not available for review. Based on interview at the time of observation, the Maintenance Director acknowledged a log of January to March 2011 thirty day interval or annual testing for each of the three battery operated emergency lights in the facility was not available for review. 3.1-19(b)		into place?A CQI tool for Life Safety Review will be utilized monthly to ensure completion of battery operated lights testing. The CQI Committee will review the data. If threshold is not achieved, an action plan will be developed.	

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K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, interview and observation; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s). This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen. Findings include: Based on record review with the Maintenance Director from 9:30 a.m. to 10:45 a.m. on 04/19/11, Fire Safety Company "Service Report" documentation indicated the kitchen exhaust system was last cleaned in	K0069	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?Documentation of semiannual kitchen exhaust cleanings will be maintained in facility.How will you identify other Residents having the potential to be affected by the same deficient practice? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practiceWhat measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?Documentation of semiannual kitchen exhaust cleanings will be maintained in the facility, and will be kept in log books in maintenance office and dietary office. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A CQI tool for Life Safety Review will be utilized weekly x 4, monthly x 2, quarterly thereafter to ensure documentation in place. The CQI Committee will review the data. If threshold is not achieved, an action plan will be developed.	05/16/2011

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	February 2011 but no documentation of semiannual cleaning prior to February 2011 was available for review. Based on interview at the time of record review, the Maintenance Director acknowledged no record of semiannual kitchen exhaust system cleaning prior to February 2011 was available for review. Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 04/19/11, a sticker tag on the kitchen exhaust system hood listed the most recent cleaning was performed in February 2011 but no other cleaning documentation was found on the kitchen exhaust hood. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to document the load percentage for the monthly load test for the generator for 1 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter	K0144	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?Monthly load testing will include recordings of the percentage load capacity and minimum exhaust gas temperatures. A generator remote annuciator to be installed.How will you identify	05/16/2011

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	6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Exercising/Load Testing" monthly load test documentation with the Maintenance Director from 9:30 a.m. to 10:45 a.m. on 04/19/11, monthly generator load testing documented on 02/04/11 and 02/28/11 show the emergency generator ran for at least thirty minutes during each documented load test but neither the percentage of load capacity or minimum exhaust gas temperature was recorded. Based on interview at the time of record review, the Maintenance Director stated the facility had a power		other Residents having the potential to be affected by the same deficient practice? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice.What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?Emergency generator excercising/load Testing will be completed and recorded monthly. The Emergency Generator Excercising/Load Testing log will include recordings for percentage load capacity and minimum exhaust gas temperatures. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A CQI tool for Life Safety Review will be utilized weekly x 4 and monthly thereafter. The CQI Committee will review the data. If threshold is not achieved, an action plan will be developed.	

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	failure on each of the stated dates which caused the emergency generator to be operated and the facility decided to record each of those dates as the February 2011 monthly load test. The Maintenance Director acknowledged neither the percentage of load capacity or minimum exhaust gas temperature was recorded during February 2011 monthly load testing. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 annunciator panels for the emergency generator would alert staff to generator alarm conditions in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning			

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WASHINGTON HEALTH CARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN46231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. This deficient practice could affect all occupants in the facility including residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 04/19/11, the facility has one emergency generator annunciator panel located across the hall from the 300 Hall nurse's station			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	and the annunciator panel has a toggle switch which was in the off position. Based on interview at the time of observation, the Maintenance Director acknowledged the emergency generator annunciator panel switch was in the off position and stated the audible alarm for the annunciator panel would not sound to alert staff if the toggle switch is in the off position. 3.1-19(b)			